Applicant's Supporting Chart for Suggested Interference between (1) U.S. Pat. Appl. Ser. No. 09/157,998 and (2) U.S. Pat. No. 6,529,876 issued March 4, 2003

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
1	A method for using a computer to facilitate E&M coding by a medical provider of a patient encounter comprising: A. inputting into the computer a code selecting An electronic template specific to a type of patient encounter; B. acquiring data prompted by the electronic template for the specific type of patient encounter for a specific patient encounter; C. inputting into the computer the data acquired for the specific type of patient encounter for the specific patient encounter; D. outputting an audit of the inputted data acquired for the specific patient encounter; E. outputting a Preliminary E&M code; F. inputting into the computer modifying variables for the specific patient encounter; G. outputting a Final E&M code;	Page 12: "Because no format can ever be expected to reflect the all the nuances of an individual patient encounter, the invention includes a method that allows the practitioner to indicate that dictation, or written or typed notes will be added. This is provided throughout the entry record, so that each addendum is linked to a specific part of the history, physical examination, or assessment and management process." Page 21: "Figures 1a-1h summarize the elements of the medical evaluation as codified by the Health Care Financing Administration (HCFA) and American Medical Association (AMA). This document is titled "Documentation Guidelines for Evaluation and Management Services." This disclosure refers to this as DG." *[APPLICANT'S NOTE – although NOT verbatim in Applicant's specification, "E&M code" in the claim/count language stands for "Evaluation and Management", as set forth on p. 21 of Applicant's specification. As just quoted from that p. 21, Applicant's specification sometimes refers to this as "DG".]* Page 27: "A score (2b5, 2c3, 2d5) is derived from each of these three sections (2b, 2c, 2d). A final score is derived from 2b5, 2c3, 2d5. There are 64 possible combinations for each of the 15 types, for a total of 960 combinations. The rules for billing differ among these categories. The invention contains category specific algorithms to determine the appropriate billing level for the service provided. In some cases (new hospital in-patient, for

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		example), there are minimum service levels that must be met before billing is allowable. The algorithm determines whether these minimum levels of service have occurred. In these cases, lower levels of service are not allowed during, for example, a hospital admission; higher levels of service are required. The invention would inform the physician when the information provided by that physician is not sufficient to justify billing. Similar scales have been constructed for the history, examination, and MDM sections."
	the method in which the step of inputting into the computer a code selecting an electronic template specific to a type of patient encounter further comprises: H. inputting into the computer a set of electronic templates and an electronic template menu;	Pages 31-32: "The database is designed so as to provide several types of output. As already described, it codes for the level of service so as to satisfy DG for billing. It also generates chart notes and correspondence. It can do this using standard templates built in to the system. For example, (figure 5b) a check on an item in the review of systems can generate an appropriate comment in the note: check off arthritis and the note can say, "The patient has a history of arthritis." The physician can modify the templates according to personal preferences for documentation." Page 39: "A process to facilitate codified data entry at point-of-service, comprising: (a) entering information on data forms"
	and in which the step of acquiring data prompted by the electronic template for the specific type of patient encounter comprises: I. examining at least one aspect of the patient encounter,	Page 9: "The format allows the health care worker to choose from short lists or to check appropriate boxes, with these organized in the order in which the particular health care worker is accustomed to acquire the information." Page 10: "The invention creates a complete structure of the patient history and physical examination." Page 11: "[I]t allows the health care worker to move in a

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		relatively linear fashion through the history and examination process." Page 15: "The invention includes questions about the patient's medical history, information about the results of physical examination, questions about medication, diagnostic options, medications, plans, and the like. It includes questions regarding the complexity of the problem that are important for medical billing purposes." Page 22: "The overall concept is to divide the process of evaluation and diagnosis into a number of elements. DG attempts to score all of the elements reflected in the record of a particular assessment. Based upon all of the sub-scores (derived from the individual elements of the examination) the system then requires the practitioner to come up with an overall 'score' which reflects the level of effort and which itself is the code which will lead to billing and reimbursement."
	and in which the step of inputting into the computer the data acquired for the specific type of patient encounter for the specific patient encounter comprises: J. inputting into the computer data acquired from the examination of the at least one aspect of the patient encounter;	Page 9: "The format allows the health care worker to choose from short lists or to check appropriate boxes, with these organized in the order in which the particular health care worker is accustomed to acquire the information." Page 15: "The invention includes questions about the patient's medical history, information about the results of physical examination, questions about medication, diagnostic options, medications, plans, and the like. It includes questions regarding the complexity of the problem that are important for medical billing purposes." Pages 28-29: "The invention as delivered to the user would contain default data elements to facilitate entry of information regarding the history, physical examination, and medical decision making (3a). It would also contain

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		default billing algorithms (3b), and default text for correspondence (3c). ... The physician enters the basic information for these sections." Page 32: "As figure 4b shows, and as reflected in the DG, there are three basic elements to the patient encounter: history, examination, and decision making process (4b1, 4b2, 4b3). The process employed by this invention is that the clinician enters data with regards to these three elements, entering the data either into a "form" (see figure 5 for an example) or by using free text (dictation, typing, etc.). The entered elements are joined together in the next stage." Page 39: "A process to facilitate codified data entry at point-of-service, comprising: (a) entering information on data forms"
	and in which the step of outputting an audit of the inputted data acquired for the specific patient encounter comprises: K. displaying and comparing the data inputted into the computer with the data required to be acquired, in examining at least one aspect of the patient encounter,	Page 11: "The invention includes questions that need to be asked in order to review the general medical state of the individual, includes items required under the HCFA documentation scheme, and includes methods for incorporating and identifying items that might be required by other payers or documentation schemes." Page 25: "The invention also can educate. For example, it can indicate what elements are needed for a given level of billing within a given type of examination." Page 27: 'In some cases (new hospital in-patient, for example), there are minimum service levels that must be met before billing is allowable. The algorithm determines whether these minimum levels of service have occurred. In these cases, lower levels of service are not allowed during, for example, a hospital admission; higher levels of service are required. The invention would inform the

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		physician when the information provided by that physician is not sufficient to justify billing. Similar scales have been constructed for the history, examination, and MDM sections." Page 39: "A process to facilitate codified data entry at point-of-service, comprising: (d) storing in data tables requirements for utilizing said entered information; (e) linking said entered information with said requirements, (f) comparing said entered information with said requirements"
	and in which the step of outputting a Preliminary E&M code comprises: L. displaying the data inputted into the computer and requiring the inputting of an acknowledgment of complete data acquisition and data inputting;	Pages 30-31: "the attending (e.g. 4a4b) could review the entries of the resident (e.g. 4a4a), make changes as may be appropriate, indicate items personally assessed, and indicate that the data has been reviewed and corrected. This permits explicit documentation of the nature of the attending's review of the resident's data entry" Page 36: "For figures 5a-d, there are buttons at the bottom labeled Prev, Next, ROS, Exam, and Done. Previous and Next take the user to the previous and next screens for that portion of the evaluation. Exam and ROS take the user to the main screen for physical examination and Review of Systems respectively. Figure 5h gives an example of an ROS "main screen," listing all the possible systems to be reviewed. Pressing "Done" indicates that the user has completed that section of the evaluation (i.e. the ROS section)."
	and in which the step of inputting into the computer modifying variables for the specific patient encounter comprises; M. identifying the modifying variables pertinent to the specific type of patient encounter; identifying the modifying variables pertinent to the	Page 15: "The invention provides a way for the health care worker to indicate what other activities were part of the encounter." Page 17: "According to DG, if "counseling" takes more than 50% of the time of the encounter, time alone can be

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	specific patient encounter;	the basis of the billing, if properly documented. The invention includes timing mechanisms to help determine if this is an appropriate basis for billing, and mechanisms for documenting the time and counseling appropriately." Page 25: "The invention also can educate. For example, it can indicate what elements are needed for a given level of billing within a given type of examination." Pages 27-28: "Alternatively, billing can occur solely based on time (2f), if counseling of the patient takes over 50% of the time of the patient encounter. There are separate rules for this. The invention includes multiple timers to allow appropriate determination of the time of the visit, and of the counseling activities, as required by certain HCFA regulations and also potentially needed for time-and-motion documentation of a health care worker's activities. It also facilitates documentation of the counseling itself." Page 28: "An important feature of this invention is that all of the data entry elements, and all of the data output elements, can be customized by clinicians to meet the specifics of their practices. Data entry elements can be added to the sections for the history, physical, and medical decision making. These added elements can be linked in to the billing schema." Page 29: The physician enters the basic information for these sections. When appropriate, the system can ask relevant questions that help the algorithm to determine which elements to score. For example, the algorithm could ask (figure 2, 2d3) whether the physician is indicating what an x-ray report described or is describing the x-ray based on personal review. Such distinctions are important for billing purposes when using the DG schema. To give another

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		example, the physician must state which type of examination was utilized (general multisystem, eye, dermatology, etc.). The system then scores the examination according to the requirements of the type of examination employed." Page 42: "separating said forms into groups comprising … counseling groups, treatment plan (including prescription) groups"
	and in which the step of outputting a Final E&M code comprises: N. displaying the data inputted into the computer, requiring the inputting of an acknowledgment of complete data acquisition and data inputting, storing by means, the Final E&M code.	Page 33: "Similarly, the method determines a code for each of the three elements of the patient encounter (4b17, 4b19, 4b21) and then determines the overall billing code (4b25), based upon the DG rules (4b24). The final text or texts (4b26) and final billing code or codes (4b27) are thus prepared." Page 33: "The rules for conversion to a text document result in text output for each of the three segments of the final note (4b16, 4b18, 4b20)." Page 39: "A process to facilitate codified data entry at point-of-service, comprising: (a) entering information on data forms, … (b) storing said entered information, (d) storing in data tables requirements for utilizing said entered information, (g) determining requirements met by said entered information, requirements comprising requirements for billing"
2	The method of claim 1 further comprising: A. the set of electronic templates comprising an electronic template for each type of patient encounter; requesting the electronic template menu; selecting by key stroke, mouse, touch pad or other menu selection means, the electronic template specific to the type of patient encounter; B. examining at the at least one aspect of	*[APPLICANT'S NOTE: MUCH OF THE LANGUAGE IN CLAIM/COUNT 2 IS SUPPORTED IN APPLICANT'S SPECIFICATION BY THE CITATIONS ALREADY SET FORTH ABOVE. SOME OF THOSE ARE REPEATED BELOW, ALONG WITH SOME ADDITIONAL CITATIONS TO OTHER PARTS OF APPLICANT'S SPECIFICATION]*

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	the patient encounter, by one or a plurality of patient encounter entities, as prompted by the selected electronic template; C. displaying aid comparing the data inputted into the computer with the data required to be acquired as prompted by the selected electronic template and requiring the inputting of an acknowledgment of complete data acquisition and data inputting for the at least one aspect of the patient encounter; D. displaying the data inputted into the computer and requiring the inputting of an acknowledgment of complete data acquisition and data inputting; and in which the step of inputting into the computer modifying variables for the specific patient encounter comprises; E. selecting the modifying variables pertinent to the specific patient encounter; inputting data representing the selected modifying variables into the computer; F. displaying the data inputted into the computer, requiring the inputting of an acknowledgment of complete data acquisition and data inputting, storing by means, the Final E&M code.	Page 9: "The format allows the health care worker to choose from short lists or to check appropriate boxes, with these organized in the order in which the particular health care worker is accustomed to acquire the information." Page 11: "The invention includes questions that need to be asked in order to review the general medical state of the individual, includes items required under the HCFA documentation scheme, and includes methods for incorporating and identifying items that might be required by other payers or documentation schemes." Page 12: "Because no format can ever be expected to reflect the all the nuances of an individual patient encounter, the invention includes a method that allows the practitioner to indicate that dictation, or written or typed notes will be added. This is provided throughout the entry record, so that each addendum is linked to a specific part of the history, physical examination, or assessment and management process." Page 15: The invention includes questions about the patient's medical history, information about the results of physical examination, questions about medication, diagnostic options, medications, plans, and the like. It includes questions regarding the complexity of the problem that are important for medical billing purposes." Page 17: "According to DG, if "counseling" takes more than 50% of the time of the encounter, time alone can be the basis of the billing, if properly documented. The invention includes timing mechanisms to help determine if this is an appropriate basis for billing, and mechanisms for documenting the time and counseling appropriately." Page 21: "Figures 1a-1h summarize the elements of the

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		medical evaluation as codified by the Health Care Financing Administration (HCFA) and American Medical Association (AMA). This document is titled "Documentation Guidelines for Evaluation and Management Services." This disclosure refers to this as DG." *[NOTE – although NOT expressly in Applicant's specification, "E&M code" in the claim/count language stands for "Evaluation and Management", as set forth on p. 21 of Applicant's specification.]* FOR (A): Page 24: "Figure 1f summarizes the scoring system for the physical examination. DG distinguishes between specialty system examinations and what is called the general multi-system examination. Nine specialty examinations are defined. For illustrative purposes, figures 1g and 1h indicate one such specialty examination, the neurological examination" Page 24: "The scoring for the physical examination varies among the various examination types (general multisystem examination and the nine specialty examinations; figure 1f1 illustrates this schematically)." Page 25: "The invention also can educate. For example, it can indicate what elements are needed for a given level of billing within a given type of examination." Page 27: "A score (2b5, 2c3, 2d5) is derived from each of these three sections (2b, 2c, 2d). A final score is derived from 2b5, 2c3, 2d5. There are 64 possible combinations for each of the 15 types, for a total of 960 combinations. The rules for billing differ among these categories. The invention contains category specific algorithms to determine the appropriate billing level for the service provided. In some cases (new hospital in-patient, for

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		example), there are minimum service levels that must be met before billing is allowable. The algorithm determines whether these minimum levels of service have occurred. In these cases, lower levels of service are not allowed during, for example, a hospital admission; higher levels of service are required. The invention would inform the physician when the information provided by that physician is not sufficient to justify billing. Similar scales have been constructed for the history, examination, and MDM sections." Page 28: "An important feature of this invention is that all of the data entry elements, and all of the data output elements, can be customized by clinicians to meet the specifics of their practices. Data entry elements can be added to the sections for the history, physical, and medical decision making. These added elements can be linked in to the billing schema." Page 29: The physician enters the basic information for these sections. When appropriate, the system can ask relevant questions that help the algorithm to determine which elements to score. For example, the algorithm could ask (figure 2, 2d3) whether the physician is indicating what an x-ray report described or is describing the x-ray based on personal review. Such distinctions are important for billing purposes when using the DG schema. To give another example, the physician must state which type of examination was utilized (general multisystem, eye, dermatology, etc.). The system then scores the examination according to the requirements of the type of examination employed." FOR C: Page 24-5: "After the physician indicates what has

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		been tested, and what kind of patient encounter is occurring, the invention determines the proper coding for this encounter, based upon the rules in the DG. ... For example, it can indicate what elements are needed for a given level of billing within a given type of examination." Page 26: ". There are different rules for each of the 15 types of encounters defined by DG (for new hospital patient, new outpatient, established patient, consultation, etc.). In some cases there are three final levels of service to be scored, in other cases five. The rules for scoring the encounter for various service levels vary among the types of encounters, so that a given level of history, of examination, or of MDM could be scored differently for each of type of encounters. It can be seen the scoring system itself is complex, and it is clear that an inadvertent error might be made because of this complexity."
3	The method of claim 2 in which the one or a plurality of patient encounter entities includes nurse station software interface, reception interface, check-in interface, check-out interface and provider interface.	Page 18: "The above gave the example of a portable handheld computer. Clearly, if this can be accomplished on a portable device, those skilled in the art can readily see that it can be accomplished on a desktop computer. More broadly, then, the method could be used on any system which included: a) a "user interface" (a method for the computer to present information to the user, such as a computer screen); b) a way of storing data and program instructions (such as a computer hard disc); and c) a means for the user to communicate with the computer (such as using a mouse, a pen input handheld computer, a keyboard, or voice dictation)." Page 12: "To give a simple example, a hospital nurse could use the invention to indicate a patient's temperature, pulse, and blood pressure, and later write down details of

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		a specific question that the patient asked or request that the patient made." Page 14: "However, the same principles apply to notes prepared by nurses and other health professionals. Not all, but a large portion of a health care worker's documentation can be systematized, so that documentation can be prepared automatically." Page 33: "Those skilled in the art can see that health care workers not subject to DG, such as nurses, could use the invention to document the patient encounter itself in the same way."
4	The method of claim 2 in which the selection of the electronic template is from the group electronic templates for types of patient encounters including general multi-system examination; cardiovascular examination; ear, nose and throat examination; eye examination; genitourinary examination; hematologic/lymphatic/immunologic examination; musculoskeletal examination, neurological examination; psychiatric examination; respiratory examination; and skin examination.	Page 11 : "The invention employs a system that allows the practitioner to encode a high percentage, perhaps three-quarters or more, of the information from a patient encounter in a simple fashion. The invention uses a combination of entry formats such as check boxes and lists, and avoids the use of multiple layers of menus. Rather, it allows the health care worker to move in a relatively linear fashion through the history and examination process. The invention takes advantage of the fact that what is done in the case of a particular encounter is fairly standard for the problem that generated the encounter." Page 11: "The invention allows development of data entry screens that relate to the data base tables." Page 12: "Because no format can ever be expected to reflect the all the nuances of an individual patient encounter, the invention includes a method that allows the practitioner to indicate that dictation, or written or typed notes will be added. This is provided throughout the entry

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		record, so that each addendum is linked to a specific part of the history, physical examination, or assessment and management process. The health care worker thus can note the majority of the pertinent information regarding the encounter while seeing the patient, and can note where dictation has been or will be added. The database engine can then generate a large percentage of the documentation, adding in any additional information that has been written, typed or dictated. When the user indicates that something is to be added, the invention also indicates how the added dictation or note fits into the HCFA (or other required) scheme." Page 15: " The invention includes questions about the patient's medical history, information about the results of physical examination, questions about medication, diagnostic options, medications, plans, and the like. It includes questions regarding the complexity of the problem that are important for medical billing purposes." Page 24: "Figure 1f summarizes the scoring system for the physical examination. DG distinguishes between specialty system examinations and what is called the general multi-system examination. Nine specialty examinations are defined. For illustrative purposes, figures 1g and 1h indicate one such specialty examination, the neurological examination" Page 24: "The scoring for the physical examination varies among the various examination types (general multisystem examination and the nine specialty examinations; figure 1f1 illustrates this schematically)." Page 26: "There are different rules for each of the 15 types of encounters defined by DG (for new hospital patient, new

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		outpatient, established patient, consultation, etc.). In some cases there are three final levels of service to be scored, in other cases five. The rules for scoring the encounter for various service levels vary among the types of encounters, so that a given level of history, of examination, or of MDM could be scored differently for each of type of encounters." Page 29: "To give another example, the physician must state which type of examination was utilized (general multisystem, eye, dermatology, etc.). The system then scores the examination according to the requirements of the type of examination employed." Page 29: "Entries into the database can be made in many ways. For example, one could use a computer-based form (4a1), be the form actually on a computer, on a handheld computer, or on paper, e.g. a form that can be scanned. In this case, the form would be designed with checklists, and the like."
5	A method for using a computer to facilitate E&M coding by a medical provider of a patient encounter comprising: A. inputting into the computer a code selecting one or a plurality of electronic template specific to one or a plurality of types of patient encounters; B. acquiring data prompted by the one or a plurality of electronic templates for the specific one or a plurality of types of patient encounter for a specific patient encounter; C inputting into the computer the data acquired for the one or a plurality of specific types of patient encounter for the specific patient encounter; D. outputting one or a plurality of audits of the inputted data acquired for the specific patient encounter; E. outputting one or a plurality of	*[APPLICANT'S NOTE: TO THE EXTENT THAT SOME OR MOST OF THIS CLAIM 5 IS SIMILAR TO CLAIM 1, APPLICANT INCORPORATES BY REFERENCE THE SUPPORTING CITATIONS SET FORTH ABOVE WITH RESPECT TO CLAIM 1, IN ADDITION TO THE CITATIONS SET FORTH HERE.]* Page 12: "When the user indicates that something is to be added, the invention also indicates how the added dictation or note fits into the HCFA (or other required) scheme." Page 28-29: This is illustrated in figure 3. The invention as delivered to the user would contain default data elements to facilitate entry of information regarding the history, physical examination, and medical decision making (3a). It

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	Preliminary E&M codes; F. inputting into the computer one or a plurality of modifying variables for the specific patient encounter; G. outputting one or a plurality of Final E&M codes;	would also contain default billing algorithms (3b), and default text for correspondence (3c). The user can add elements to any section (an example is shown in 3e) and can define text output for these new elements (3g). The algorithm automatically adjusts for the presence of the new element (3f). In the example, there were four elements available and entered initially during a hypothetical encounter, one was added to the template. The user added an element (data element a, figure 3e). The user actually used all 5 of the elements now available when seeing a patient. The billing module detected this and scored accordingly (3f). Text output was automatically created for the five elements."
	the method of inputting into the computer a code selecting one or a plurality of electronic templates specific to one or a plurality of types of patient encounters further comprises: H. inputting into the computer a set of electronic templates and an electronic template menu; requesting the electronic template menu;	
	and in which the step of acquiring data prompted by the one or a plurality of electronic templates for the one or a plurality of specific type of patient encounter comprises: I. examining at least one aspect of the patient encounter,	
	and in which the step of inputting into the computer the data acquired for the one or a plurality of specific types of patient encounter for the specific patient encounter comprises: J. inputting into the computer data acquired from the examination of the at least one aspect of tie patient encounter;	

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	and in which the step of outputting one or a plurality of audits of the inputted data acquired for the specific patient encounter comprises; K. displaying and comparing the data inputted into the computer with the data required to be acquired, in examining at least one aspect of the patient encounter;	
	and in which the step of outputting one or a plurality of Preliminary E&M codes comprises: L. displaying the data inputted into the computer and requiring the inputting of one or a plurality of acknowledgments of complete data acquisition and data inputting; and in which the step of inputting into the computer one or a plurality of modifying variables for the specific patient encounter comprises; M. identifying the one or a plurality of modifying variables pertinent to the one or a plurality of specific types of patient encounter; identifying the one or a plurality of modifying variables pertinent to the specific patient encounter;	
	and in which the step of outputting one or a plurality of Final E&M codes comprises: N. displaying the data inputted into the computer, requiring the inputting of one or a plurality of acknowledgments of complete data acquisition and data inputting, storing by means, the one or a plurality of Final E&M codes.	
6	The method of claim 5 further comprising: A. inputting into the computer the set of electronic templates comprising an electronic template for each type of patient encounter, selecting by key stroke, mouse, touch pad or other menu selection means, one or a plurality of electronic template specific to the type of patient encounter; B. examining the at least	*[APPLICANT'S NOTE: TO THE EXTENT THAT SOME OR MOST OF THIS CLAIM 6 IS SIMILAR TO CLAIM 2, APPLICANT INCORPORATES BY REFERENCE THE SUPPORTING CITATIONS SET FORTH ABOVE WITH RESPECT TO CLAIM 2.]*

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	one aspect of the patient encounter by one or a plurality of patient encounter entities, as prompted by the one or a plurality of the selected electronic templates; C. displaying and comparing the data inputted into the computer with the data required to be acquired as prompted by the selected one or a plurality of electronic templates and requiring the inputting of one or a plurality of acknowledgments of complete data acquisition and data inputting for the at the least one aspect of the patient encounter; D. selecting the one or a plurality of modifying variables pertinent to the specific patient encounter; inputting data representing the selected one or a plurality of modifying variables into the computer.	
7	The method of claim 6 in which the one or a plurality of patient encounter entities includes nurse station software interface, reception interface, check-in interface, check-out interface and provider interface.	Page 18: "The above gave the example of a portable handheld computer. Clearly, if this can be accomplished on a portable device, those skilled in the art can readily see that it can be accomplished on a desktop computer. More broadly, then, the method could be used on any system which included: a) a "user interface" (a method for the computer to present information to the user, such as a computer screen); b) a way of storing data and program instructions (such as a computer hard disc); and c) a means for the user to communicate with the computer (such as using a mouse, a pen input handheld computer, a keyboard, or voice dictation)." Page 12: "To give a simple example, a hospital nurse could use the invention to indicate a patient's temperature, pulse, and blood pressure, and later write down details of a specific question that the patient asked or request that the patient made."

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
		Page 14: "However, the same principles apply to notes prepared by nurses and other health professionals. Not all, but a large portion of a health care worker's documentation can be systematized, so that documentation can be prepared automatically." Page 33: "Those skilled in the art can see that health care workers not subject to DG, such as nurses, could use the invention to document the patient encounter itself in the same way."
8	The method of claim 6 in which the selection of the one or a plurality of electronic templates is from the group electronic templates for types of patient encounters including general multi-system examination; cardiovascular examination; ear, nose and throat examination; eye examination; genitourinary examination; hematologic/lymphatic/immunologic examination; musculoskeletal examination, neurological examination; psychiatric examination; respiratory examination; and skin examination.	Page 24: "The scoring for the physical examination varies among the various examination types (general multisystem examination and the nine specialty examinations; figure 1f1 illustrates this schematically)." Page 29: "To give another example, the physician must state which type of examination was utilized (general multisystem, eye, dermatology, etc.). The system then scores the examination according to the requirements of the type of examination employed." Page 29: "Entries into the database can be made in many ways. For example, one could use a computer-based form (4a1), be the form actually on a computer, on a handheld computer, or on paper, e.g. a form that can be scanned. In this case, the form would be designed with checklists, and the like."
9	The method of claim 6 in which the step of acquiring data prompted by the electronic template for the specific type of patient encounter comprises: A. conducting an examination of at least a history component, a physical component and a medical decision component, by one or a plurality of patient encounter entities, as prompted by the selected	Page 10: "Finally, the present invention differs from its predecessors in that it explicitly combines the HCFA regulations into the broader set of all the history, physical examination, and patient care items that might be part of a given patient evaluation. The same can be accomplished easily for any other third-party regulations pertinent to medical care documentation. The invention creates a

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	electronic template;	complete structure of the patient history and physical examination." Page 34: "An example of a table of values is shown in figure 4c, for initial hospital visits. The table is a codification of the Initial Hospital Care sections in Physicians' Current Procedural Terminology, Fourth Edition, CPT1998, published by the American Medical Association Column b row 2 shows 3/3, indicating that all three "scores" must be at the given level to justify a level of billing. Column c, row 1, shows the first four numbers of the billing code. The final number is listed below in the table as follows. The three elements, as noted above are A (history), B (Examination), and C (MDM). As described above, for history and for the examination there are four levels of effort (1-problem focused; 2-expanded problem focused; 3-detailed; 4-comprehensive). For MDM there similarly are four levels (1-straightforward; 2-low complexity; 3-moderate complexity; 4-high complexity). The numbers 331, 1, and 30 in column d indicate that the minimum value for a final score of 99221, A must equal at least 3, B equal at least 3, and C equal at least 1. The table then looks at all possible combinations of A, B, and C and lists what the final code would be. It indicates the combinations (denoted by n in the example) for which services can't be billed. The method is so constructed to allow changes in the codes as changes in DM occur. Simply changing the values, scale, or table could accommodate a different schema, for example from an insurance company."
	and in which the step of inputting into the computer the data acquired for the specific type of patient	Page 28: "Data entry elements can be added to the sections for the history, physical, and medical decision making."

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	encounter for the specific patient encounter comprises: B. inputting into the computer data acquired from the examination of the at least a history component, a physical component and a medical decision component for the patient encounter;	Page 11: "The invention uses a combination of entry formats such as check boxes and lists, and avoids the use of multiple layers of menus. Rather, it allows the health care worker to move in a relatively linear fashion through the history and examination process. The invention takes advantage of the fact that what is done in the case of a particular encounter is fairly standard for the problem that generated the encounter. This is true for all health care workers, and in the case of physicians, for both for generalists and specialists. The invention includes questions that need to be asked in order to review the general medical state of the individual, includes items required under the HCFA documentation scheme, and includes methods for incorporating and identifying items that might be required by other payers or documentation schemes. All information is entered into a database. The invention allows development of data entry screens that relate to the data base tables. The invention allows the portable handheld computer to exchange information with any standard database." Pages 28-29: "The invention as delivered to the user would contain default data elements to facilitate entry of information regarding the history, physical examination, and medical decision making (3a). It would also contain default billing algorithms (3b), and default text for correspondence (3c). ... The physician enters the basic information for these sections." Page 32: "As figure 4b shows, and as reflected in the DG, there are three basic elements to the patient encounter: history, examination, and decision making process (4b1, 4b2, 4b3)."

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	and in which the step of outputting an audit of the inputted data acquired for the specific patient encounter comprises: D. displaying and comparing the data inputted into the computer with the data required to be acquired, for the at least a history component, a physical component and a medical decision component for the patient encounter, as prompted by the selected electronic template and requiring the inputting of an acknowledgment of complete data acquisition and data inputting for the at least a history component, a physical component and a medical decision component of the patient encounter; E. outputting a Preliminary E&M code; F. inputting modifying variables; G. outputting a Final E&M code.	*[APPLICANT'S NOTE: SEE CITATIONS ABOVE]*
10	The method of claim 9 in which the step of acquiring data prompted by the electronic template for the at least a history component comprises: A. taking, at a patient encounter, the Chief Complaint/History of Present Illness(CCHPI); taking the Past Family Social History(PFSH) and making a Review of Systems(ROS);	Page 22: "The history is divided into the history of present illness per se, the review of systems, and the past, family and social history." Page 42: (Claim 9(a)): "separating said forms into groups comprising patient demographics groups, medical history groups, past medical history groups, review of systems or review of symptoms groups, family history groups, social history groups, physical examination groups, medical decision making groups, counseling groups, treatment plan (including prescription) groups" SEE ALSO Figure 2 (2b2, 2b3, 2b4)
	and in which the step of acquiring data prompted by the electronic template for the at least a physical component comprises: B. conducting a physical exam;	Page 22: "The physical examination can comprise one or more of 7 body areas or 12 organ systems." SEE ALSO Figure 2 (2c2)
	and in which the step of acquiring data prompted by the electronic template for the at least a medical decision component comprises: C. making a data	Page 22: "Complexity of medical decision making pertains to the number of options available, the risks to the patient of the illness, diagnostic procedure, or treatment,

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	evaluation; making a diagnosis; making a risk assessment;	and the type, amount, and complexity of data which need to be evaluated during the encounter." SEE ALSO Figure 2 (2d2, 2d3, 2d4)
	and in which the step of inputting into the computer the data acquired from the examination of the at least a history component: D. inputting the data of the taking of the CCHPI; inputting the data of the taking of the PFSH, inputting the data of the making of the ROS;	In addition to the other citations above, Figures 1(a)-(e), 2 and 4(b) and related text in the specification (re: taking a history) support this.
	and in which the step of inputting into the computer the data acquired from the examination of the at least a physical component: F. inputting the data of the making of the physical exam;	In addition to the other citations above, 1(f)-(h), 4(b) and related text in the specification (re: taking an examination and inputting the data) support this.
	and in which the step of inputting into the computer the data acquired the examination of the at least a medical decision component: H. inputting the data from making the data evaluation; inputting the data from making the diagnosis; inputting the data from making the risk assessment;	Page 40: "entering said information into said forms by an input means of the user's preference" In addition to the other citations above, 1(i), 1(j), 2 and 4(b) and related text in the specification (re: medical decision making (at least generally)) support this.
	and in which the step of outputting an audit of the data for the at least a history component: I. displaying and comparing the data inputted into the computer with the data required to be acquired as prompted by the selected electronic template, for the at least a history component from the taking of the CCHPI; for the taking of the PFSH; and for the making of the ROS; requiring the inputting of an acknowledgment of complete data acquisition and data inputting for the taking of the CCHPI producing a CCHPI Code Level; for the taking of the PFSH producing a PFSH Code Level; and for the making of the ROS producing a	Page 36: "For figures 5a-d, there are buttons at the bottom labeled Prev, Next, ROS, Exam, and Done. Previous and Next take the user to the previous and next screens for that portion of the evaluation. Exam and ROS take the user to the main screen for physical examination and Review of Systems respectively. Figure 5h gives an example of an ROS "main screen," listing all the possible systems to be reviewed. Pressing "Done" indicates that the user has completed that section of the evaluation (i.e. the ROS section)." Page 39: (Claim1): " (f) comparing said entered information with said requirements, (g) determining

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	ROS Code Level;	requirements met by said entered information, requirements comprising requirements for billing, for text output such as correspondence, for quality control, for internal record keeping," SEE ALSO Figures 2 and 4(b).
	and in which the step of outputting an audit of the data for the at least a physical component: J. displaying and comparing the data inputted into the computer with the data required to be acquired as prompted by the selected electronic template, for the at least a physical component from the making of the physical exam; requiring the inputting of an acknowledgment of complete data acquisition and data inputting for the making of the physical exam producing a physical code level;	*[APPLICANT'S NOTE: SEE CITATIONS ABOVE]*
	and in which the step of outputting an audit of the data for the at least a medical decision component: K. displaying and comparing the data inputted into the computer with the data required to be acquired as prompted by the selected electronic template, for the at least a medical decision component from the making of the data evaluation; from the making of the diagnosis, and from the making of the risk assessment; requiring the inputting of an acknowledgment of complete data acquisition and data inputting for the making of the data evaluation producing a data evaluation code level, for the making of the diagnosis producing a diagnosis code level, and the making of the risk assessment producing a risk assessment code level; from the making of the physical exam producing a physical code level;	*[APPLICANT'S NOTE: SEE CITATIONS ABOVE]*

Count No.	*Claim/Count Language*	*Written Description in Applicant's Specification, including Constructive Reduction to Practice*
	and in which the step of outputting a Preliminary E&M code comprises: L. combining the CCHPI code level, the PFSH code level and the ROS code level producing the Lowest Code Level and the History Code Level; combining the data evaluation code level, the diagnosis code level and the risk assessment code level producing the Level of Highest Two Code Levels and the Medical Decision Code Level; combining the History Code Level, the Physical Code Level and the Medical Decision Code Level producing the Patient Encounter Category; selecting from the Patient Encounter Category the Lowest of 3 Code Levels or the Highest Two Code Levels producing the Preliminary E&M code.	Page 2: "A method is described which simplifies, automates and organizes the creation of notes and correspondence and also, by performing the calculations needed to determine the appropriate billing codes, provides documentation for billing purposes, and assists the health care worker in determining the proper billing code." Page 14: "The HCFA scoring system is complex, but it can be reduced to an algorithm. The algorithm is too complex for clinicians to calculate levels reliably in the course of a busy practice. Clinicians can be expected, however, to know what they actually do. Develop a simple means to allow them to document what they are doing when they do it. Allow them to use a simple check list format which will interfere as little as possible with clinical care. Make this microprocessor based so that the check list responses "fill in the blanks" of a database. Develop an algorithm that checks responses in the database and uses these to "score" the patient encounter. The microprocessor then can calculate the billing level based upon the algorithm." SEE ALSO Figures 1(i) and 4(c).

Z:\WinWord\TAMAR\P2630\Interference Materials\ClaimChart_FINAL.doc